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MEASURING PROGRESS ON REPOSITIONING FAMILY PLANNING IN TANZANIA

JUNE 2013

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The project and the authors of this report also wish to thank the stakeholders who participated in the March 26–27 workshop or were interviewed following the workshop. These stakeholders represented government, donor organizations, and local and international nongovernmental organizations, and bring decades of experience to the effort to strengthen family planning in Tanzania.

ABBREVIATIONS

AFP	Advanced Family Planning
AusAID	Australian Agency for International Development
CBD	community-based distribution
CCHP	comprehensive council health plans
CHW	community health worker
CIDA	Canadian International Development Agency
CSO	civil society organization
DFID	Department for International Development
FP	family planning
FP TWG	Family Planning Technical Working Group
HIV	human immunodeficiency virus
HMIS	health management information systems
HSSP	Health Sector Strategic Plan
IR	intermediate result
JHU-CCP	Johns Hopkins University - Center for Communication Programs
JSI	John Snow Incorporated
M&E	monitoring and evaluating
MEC	medical eligibility criteria
MNCH	maternal, newborn and child health
MNPI	Maternal and Neonatal Program Index
MOEVT	Ministry of Education and Vocational Training
MOHSW	Ministry of Health and Social Welfare
MP	Member of Parliament
MSD	medical stores department
MST	Marie Stopes Tanzania
NFPCIP	National Family Planning Costed Implementation Plan
NGO	nongovernmental organization
NHA	national health accounts
NSGRP	National Strategy for Growth and Reduction of Poverty II
PMORALG	Prime Minister's Office-Regional and Local Governments
PPP	public-private partnership
PRSP	poverty reduction strategy papers
RCHS	Reproductive and Child Health Section
RH	reproductive health
SO	strategic objective
SPR	selected practice recommendations
TWG	technical working group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

Demographic pressures and lack of progress toward the Millennium Development Goals have encouraged countries and donors to take a new look at family planning. Since 2001, the United States Agency for International Development (USAID), the World Health Organization (WHO), and other important partners have joined with national governments in sub-Saharan Africa in an initiative, known as *Repositioning Family Planning*, to raise the priority for family planning (FP) programs. The initiative was established to ensure that family planning remains a priority for donors, policymakers, and service providers in sub-Saharan Africa in an era when HIV, malaria, and tuberculosis programs dominate the global health agenda and receive a majority of the resources.

Although family planning is one of the most cost-effective, high-yield interventions for improving health and accelerating development, many countries in sub-Saharan Africa are unable to ensure widespread and consistent availability of FP methods. There is substantial demand in Tanzania, with an estimated one-fourth of currently married women expressing an unmet need for family planning.¹ With an average of 5.4 children per woman, Tanzania has a high fertility rate and rapidly growing population.² High fertility leads to many unplanned pregnancies that pose serious health risks for mothers and children.

The goal of USAID's Repositioning Family Planning initiative is to increase political and financial commitment to family planning in sub-Saharan Africa, which will lead to expanded access and help meet women's stated desires for safe and effective modern contraception. The initiative identified three key approaches or intervention areas for achieving this goal: (1) advocating for policy change, (2) strengthening leadership, and (3) improving capacity to deliver services.³ While many activities are underway to reposition family planning, most countries lack a mechanism for assessing the success of their efforts.⁴ In 2011, in response to this gap, the MEASURE Evaluation Population and Reproductive Health project developed a results framework to assess efforts to reposition family planning. The *Framework for Monitoring and Evaluating (M&E) Efforts to Reposition Family Planning* (M&E framework) can be used by international donors, governments, and health programs to evaluate their efforts; identify gaps in strategies to reposition family planning in countries; and inform funding decisions, program design, policy and advocacy, and program planning and improvement. After MEASURE Evaluation conducted an initial pilot test in Tanzania, the USAID-funded Health Policy Project adapted and pilot tested the framework in Togo and Niger. Futures Group, with funding from the Hewlett Foundation, then applied the framework in six additional West African countries.

Stakeholders in West Africa and donor representatives expressed an interest in visually presenting and communicating the information collected through application of the M&E framework and indicators to monitor progress toward repositioning family planning. MEASURE Evaluation developed a simple decision support tool to accompany the framework and indicators. This tool will provide visualization of some of the indicators and feedback on progress to support decisionmaking.

The USAID-funded Health Policy Initiative, Task Order 5 (HPI) applied the M&E framework and the accompanying decision support tool again in Tanzania (two years after the initial pilot) to identify policy priorities in family planning. Project staff used the decision support tool to guide discussion among a selected group of stakeholders in Tanzania to respond to the M&E framework indicators. This report presents the results of this application, which can serve as a progress update and basis for policy action on family planning.

¹ National Bureau of Statistics (NBS) [Tanzania] and ICF Macro. 2011. Tanzania Demographic and Health Survey (TDHS) 2010. Dar es Salaam, Tanzania: NBS and ICF Macro. Retrieved from <http://www.statcompiler.com/>.

² TDHS, 2010. Retrieved from <http://www.statcompiler.com/>.

³ United States Agency for International Development (USAID). 2006. "Repositioning Family Planning in Sub-Saharan Africa: An Issue Brief." Washington, DC: USAID. Retrieved September 6, 2012, from http://transition.usaid.gov/our_work/global_health/pop/techareas/repositioning/briefs/repo_subafr.pdf.

⁴ Judice, N., and E. Snyder. 2012. "Framework for Monitoring and Evaluating Efforts to Reposition Family Planning." Washington, DC: Futures Group. Retrieved June 19, 2013, from <http://www.cpc.unc.edu/measure/publications/SR-12-63>.

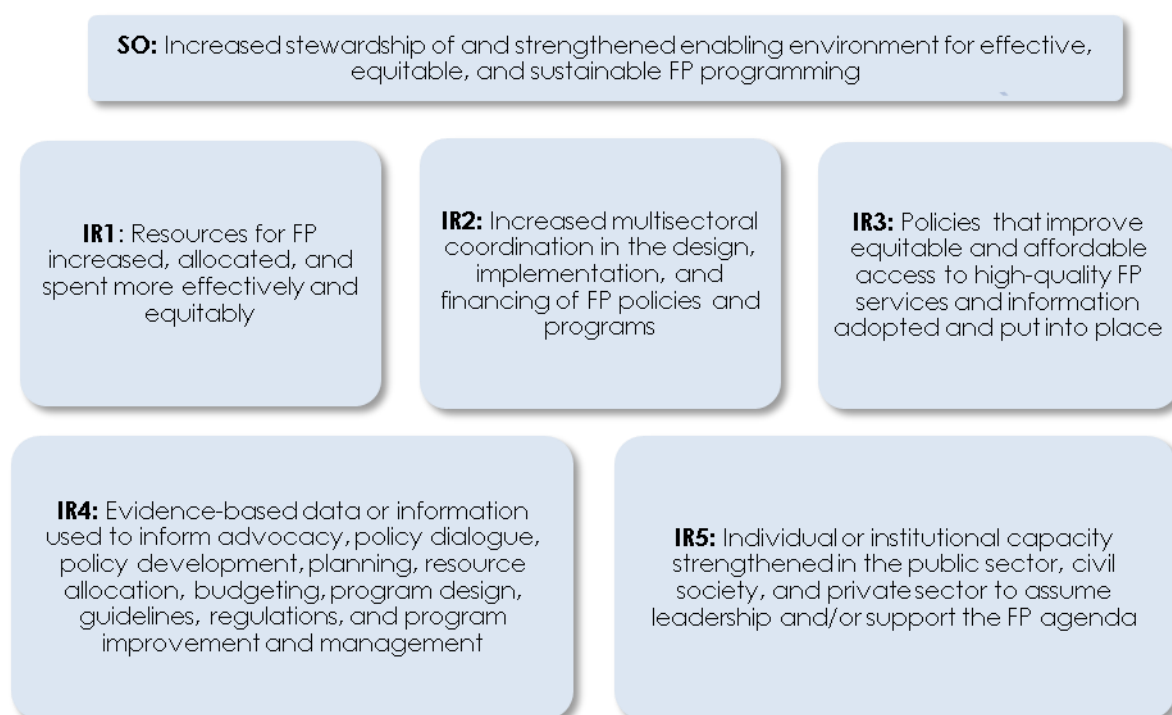
FRAMEWORK FOR ASSESSING THE REPOSITIONING FP INITIATIVE

The overall strategic objective (SO) of the *Framework for Monitoring and Evaluating (M&E) Efforts to Reposition Family Planning* (the M&E framework) is “Increased stewardship of and strengthened enabling environment for effective, equitable, and sustainable FP programming.” Under the SO, there are three illustrative indicators:

1. Instances of a government-led council, coalition, or entity that oversees and actively manages the FP program;
2. Instances of documented improvement in the enabling environment using a validated instrument; and
3. Evidence of FP policies implemented and resources allocated and subsequently used in relation to the same FP policy.

Each IR has specific indicators that contribute to overall achievement of the IR (see Figure 1).

Figure 1. Results Framework for Strengthening Commitment to and Increased Resources for Family Planning



Source: Judice and Snyder, 2012.

Methodology

After the M&E framework and indicators were field tested in Tanzania in 2011 and finalized, staff of the USAID-funded Health Policy Project, implemented by Futures Group, reviewed the tools developed for Tanzania and subsequently adapted them for use in West Africa and translated them into French. The project team then tested the M&E framework in Togo and Niger. In 2012, Futures Group applied the M&E framework in six additional countries of Francophone West Africa with

Hewlett Foundation funding⁵ and proposed a revised methodology for applying the framework in these countries. Futures Group first assembled a team of four people to test a more participatory and interactive methodology in Mali. Based on the successful results, the team decided to use the Mali methodology for the five remaining countries. Based on this approach, HPI/Tanzania decided to use a methodology with a participatory focus in Tanzania in 2013.

Additionally, stakeholders in West Africa, as well as donor representatives, expressed an interest in visually presenting and communicating the information collected through application of the M&E framework and indicators to monitor progress towards repositioning family planning. MEASURE Evaluation developed a simple decision support tool to accompany the framework and indicators. This tool will provide visualization of some of the indicators and feedback on progress to support decisionmaking. HPI/Tanzania used the decision support tool in its first pilot test to guide discussion among a selected group of FP stakeholders in Tanzania on responding to the M&E framework indicators.

The authors began by reviewing policies, strategies, program materials, and other information related to the framework indicators. Some documents were found online or in electronic format. In preparation for the meeting, the team printed two key documents to use for the working meeting:

1. Framework for *Monitoring and Evaluating (M&E) Efforts to Reposition Family Planning*
2. Explanation of Indicators

The HPI/Tanzania team collaborated with the Reproductive and Child Health Section (RCHS) of Tanzania's Ministry of Health and Social Welfare (MOHSW) to conduct a two-day technical meeting with 16 stakeholders. Stakeholders invited included government officials, representatives of international and national nongovernmental organizations (NGOs), and other partners. The meeting, held on March 26–27, 2013, consisted of an orientation to the M&E framework, presentation of the initial findings from the pilot test, and group discussions to inform each of the IRs and indicators. The decision support tool was filled out as the meeting progressed. The tool provides a series of guiding questions for the group to consider in scoring each indicator. As a group answers the questions and scores performance on a given indicator, that score is represented visually by a color—bright green, yellow, orange, or red. Bright green represents strong performance, and red represents a gap in performance that requires urgent attention. Colors also were vetted and discussed by participants.

The workshop concluded with several recommendations to strengthen efforts to reposition family planning in Tanzania. The HPI/Tanzania team also identified a few stakeholders who had information to contribute but had not attended the meeting; the team interviewed them after the workshop.

Study Limitations

Not everyone identified as key actors in family planning were available for the meeting or interviews. Some data and information were not available. Despite these limitations, this assessment provides an important progress update for repositioning family planning in Tanzania.

⁵ The six countries are Benin, Burkina Faso, Guinea, Mali, Mauritania, and Senegal.

ASSESSMENT FINDINGS

This section presents the findings from the application of the M&E framework and decision support tool. The findings are presented according to the SO indicators and intermediate results, as delineated in the framework.

SO: Increased stewardship of and strengthened enabling environment for effective, equitable, and sustainable FP programming

Stewardship in this framework is defined as the responsible and attentive management of something entrusted to one's care. Stewardship is one of the six building blocks in WHO's health systems framework.⁶ The WHO principles defining stewardship for the overall health system may be adapted to family planning and map clearly to the M&E framework, as in the following examples:

- Overseeing and guiding the overall provision of FP services provided by private as well as public sources to protect the public interest (SO);
- Collaborating and coalition building across sectors in government and with actors outside of government to influence action on key determinants of population and access to FP services (IR2);
- Regulation and the design of performance measures, and ensuring that they uphold the principles of voluntariness and informed choice in family planning (IR3 and IR5); and
- Ensuring accountability and transparency in the delivery of FP services (SO).

FP and reproductive health programs are often the responsibility of the public sector; however, family planning may not be a priority in a particular country. Stewardship of the FP programs ensures continued support for family planning, even when donor priorities or private sector priorities shift.

Strategic Objective Indicator 1: Instances of a government-led council, coalition, or entity that oversees and actively manages the FP program

The National Family Planning Technical Working Group (FP TWG) in Tanzania is a multisectoral advisory entity responsible for planning and oversight of the FP program. While government representatives serve in a leadership role for the group, with the National Family Planning Coordinator in the Reproductive and Child Health Section of the MOHSW as the chair of the group, key informants report that the success of TWG efforts is dependent on the time and resources contributed by donors and donor-funded organizations. The group works actively to ensure contraceptive security in the face of threatened stockouts and has successfully developed and advocated to the government to adopt a Costed Implementation Plan, which provides detailed roles, responsibilities, and cost implications for repositioning and reinvigorating access to and use of FP services in Tanzania.

Strategic Objective Indicator 2: Evidence of documented improvement in the enabling environment for family planning, using a validated instrument

Data from three validated instruments are available to assess the enabling environment for family planning in Tanzania. The *Family Planning Program Effort Index* was developed as an international measure to gauge key areas of each country's FP program.⁷ The Index scores are based on the average scores submitted by 10–15 local experts on 30 indicators related to policies, services, evaluation, and access to FP methods. Tanzania's score did not fluctuate greatly between the two most recent years of

⁶ World Health Organization (WHO). 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva: WHO.

⁷ Ross, John, and Ellen Smith. 2010. "The Family Planning Effort Index: 1999, 2004, and 2009."

Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1. Retrieved June 19, 2013, from http://www.healthpolicyinitiative.com/Publications/Documents/1110_1_FP_Effort_Index_1999_2004_2009_FINAL_05_08_10_acc.pdf.

data collection—from 45 in 2004 to 47 in 2009.⁸ As the highest score is 100, the scores also indicate considerable room for improvement in Tanzania.

The *Contraceptive Security Index* uses a rating system that assigns points to 17 indicators related to the supply chain, finance, the health and social environment, access to family planning, and use of family planning. The scores for Tanzania were 52 in 2006 (with a regional average of 48),⁹ and 54 in 2009,¹⁰ out of a possible 100 points. These scores indicate a relatively low level of contraceptive security, with little improvement since 2006. Policymakers and program managers need to increase their efforts to ensure that adequate contraceptive supplies are widely available.

The *Maternal and Neonatal Program Index* (MNPI) was developed as an international measure to gauge a country's efforts at providing access to high-quality maternal and neonatal health services.¹¹ The MNPI also includes policy environment and systems measurements. The scores for Tanzania have increased steadily since 1999, when they were 58, to 66 in 2002 and 70 in 2005. In each of these years, the scores surpassed the regional scores.

Strategic Objective Indicator 3: Evidence of FP policies implemented, resources allocated, and subsequently used in relation to the same FP policies

This indicator represents achievement across two different IRs, as described below. The first is evidence of FP policies implemented (IR 3.5), and the second is resources allocated (IR 1.3) and subsequently used (IR 1.1).

Intermediate Result 1: Resources for family planning increased, allocated, and spent more effectively and equitably

The M&E Framework lists the following four indicators related to resources for family planning:

- IR1.1: Total resources *spent* on family planning (by source and activity/program area)
- IR1.2: Evidence of new financing mechanisms for family planning identified and tested
- IR1.3: Total resources *allocated* to family planning (by source and activity)
- IR1.4: New and/or increased resources are committed to family planning in the last two years

This IR describes improvement in a key element of the FP policy-enabling environment. Nearly all respondents interviewed by MEASURE Evaluation Population and Reproductive Health (PRH) Project staff in the development of this framework underscored the importance of “evidence of action.” One representative of an international organization asserted, “It doesn’t make sense to bump up something to the forefront without thinking about whether or not there are resources to pick it up when you leave.” Increased resources for family planning serve as evidence to document that action.

In this framework, increased resources do not refer only to financial resources, but can also be material, such as additional doctors, new facilities, furniture, and vehicles. Resources can derive from many sources, including national/subnational governments, NGOs, donors, individuals, and foundations. There are several possible mechanisms for increasing the pool of resources available for

⁸ Ross, John, and Ellen Smith. 2010. “The Family Planning Effort Index: 1999, 2004, and 2009.” Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1. Retrieved June 19, 2013, from http://www.healthpolicyinitiative.com/Publications/Documents/1110_1_FP_Effort_Index_1999_2004_2009_FINAL_05_08_10_acc.pdf.

⁹ USAID | DELIVER Project. 2006. “Contraceptive Security Index 2006: A Tool for Priority Setting and Planning.” Arlington, VA: USAID | DELIVER Project. Retrieved September 9, 2012, from http://deliver.jsi.com/dlvr_content/resources/allpubs/factsheets/CSIndex_2006_Book.pdf.

¹⁰ USAID | DELIVER Project, Task Order 1. 2009. “Contraceptive Security Index 2009: A Tool for Priority Setting and Planning.” Arlington, VA: USAID | DELIVER Project, Task Order 1. Retrieved September 9, 2012, from http://deliver.jsi.com/dlvr_content/resources/allpubs/factsheets/CSIndex_WallChart_WebBklet.pdf.

¹¹ USAID | Health Policy Project. “MNPI: Maternal and Neonatal Program Effort Index.” Retrieved June 19, 2013, from <http://www.policyproject.com/pubs/mnpi.cfm>.

health-related activities, including line items in budgets, money from government budgets, donor funds, taxes, user fees, privatization, community-based financing, and health insurance schemes. This selection of indicators can help to track the sustainability of family planning in a country.

IRI.1: Total resources spent on FP (by source and by activity/program area)

The team identified several donors, bilateral agreements, and international NGOs that support family planning. Currently, the United Republic of Tanzania provides very limited funding for family planning in its national budget, largely allocating funds to family planning from the funding basket for the health sector. This basket fund is a pooled funding mechanism, which allows partners (foreign governments and other donors) to contribute funds to the health sector to complement Tanzanian government investments and contributions. Contributing donors to the basket fund and the Government of Tanzania first agree upon particular spending areas before they put money into the pooled mechanism, but the Permanent Secretary of the MOHSW ultimately chooses how to use the funds within the agreed spending areas. Before the money is spent, the MOHSW has to receive a “no objection” letter from the World Bank.

In Tanzania, districts may choose to allocate funding to FP activities in their Comprehensive Council Health Plans (CCHPs). Districts are provided with a budget ceiling and guidelines on allocating funding. Districts may face an extensive list of priorities, and advocacy for and data on the benefits of family planning is required to increase the amount of its funding. Stakeholders at the workshop and in interviews confirmed that districts must obtain FP commodities from the medical stores department (MSD)—the central procurement entity.

Tanzania receives a significant proportion of its FP resources from foreign sources. During 2008–2011, USAID provided increasing amounts for FP programs, from US\$10.9 million in 2008 to US\$22.6 million in 2011 (see Table 1).¹² Likewise, new donors for contraceptives, such as the Australian Agency for International Development (AusAID) and the Department for International Development (DFID), have emerged in the last few years to help ensure contraceptive security. In FY 2011, AusAID provided US\$3.12 million and DFID provided US\$3 million for the purchase of contraceptive commodities.

Table 1. USAID Funding for Family Planning in Tanzania, 2008–2011

	Years, millions US\$			
	2008	2009	2010	2011
Family Planning and Reproductive Health	10.9	17	20	22.6

Source: USAID, 2012.

To itemize and track the level of resources needed to support family planning in Tanzania, the FP TWG developed a National Family Planning Costed Implementation Plan (NFPCIP). The Working Group actively monitors implementation of the NFPCIP. In Year 1 of the NFPCIP (2011–2012), partners reported spending US\$28,223,281 on commodities, capacity building, service delivery, advocacy, and management/health management information systems (HMIS). In Year 2 (2012–2013), partners reported spending US\$45,628,572. Both years vastly exceeded the targets set during the design of the NFPCIP. At this midpoint in the NFPCIP’s implementation, the TWG has elected to revise targets, forecasts, and needs to more accurately reflect the reality of costs and targets for FP implementation in Tanzania.

¹² USAID/Tanzania. 2012. “Fact Sheet: FY 2008–11 USAID-State Foreign Assistance Appropriations.”

While National Health Accounts (NHA) expenditure data have been collected over the past decade, stakeholders at the workshop and those interviewed following it consistently stated that the FP community does not use NHA data. They expressed a general concern about the lack of transparency in how these data are obtained and compiled.

IRI.2: Evidence of new financing mechanisms for family planning identified and tested

In mid-2011, the donor community and NGOs worked with the government to successfully advocate for a new budget line for family planning to be added to the national budget. According to the workshop participants, this line item has been allocated very little funding from the Government of Tanzania, compared to the country's actual needs.

At the district level, organizations such as Deloitte, Abt Associates, Pathfinder, and EngenderHealth are supporting accountability and new financing mechanisms. Pathfinder currently is conducting a study on district-level advocacy with Ifakara. Some districts have begun budgeting for commodities, and others have budgeted for specific FP activities.

NGOs and private clinics have received targeted investments from bilateral donors, such as the Canadian International Development Agency (CIDA), and have been innovative in their use of public-private partnerships. For example, Marie Stopes Tanzania (MST) helps cover the costs of government staff and their per diem to participate in FP outreach.

IRI.3: Total resources allocated to FP (by source and by activity)

Funding allocation and expenditure is complicated in Tanzania. At the district level, the Prime Minister's Office – Regional and Local Governments (PMORALG) plays a strong role, but the PMORALG is rarely included in national budgetary discussions about the health sector. Stakeholders noted that "local governments are left responsible but not empowered to solve the problems."

Staff salaries and commodities are funded at the central level, which means that district funding is used for training, strengthening counseling, or field visits and local meetings on family planning. This allows districts to direct some resources to meet local FP needs, but hampers their ability to respond to local staffing or commodity needs. Nonetheless, districts increasingly are prioritizing FP in local budgets. EngenderHealth conducted an assessment of CCHPs to identify which districts included family planning. Out of 141 districts, it sampled 49 (35%) and found that all of them (100%) included family planning in their 2012 CCHPs (though in most cases, levels of funding were modest). Of these districts, 85 percent of the funds budgeted for family planning were released or spent, compared to 75 percent in 2009.¹³

As described above, much FP funding is provided by donor organizations or through bilateral agreements with other governments. When donors allocate funding in their budgets for family planning, it is often the amount they actually release and spend.

In 2011, the government created a line item in the national budget for family planning (see IR 1.4 below). It has allocated 1 billion Tanzanian Shillings (approximately US\$611,000) in the line item for the upcoming budget year (2013/14).

IRI.4: New and/or increased resources are committed to FP in the last two years

Donor organizations and governments continue to commit increased resources to family planning over the last two years (as described above). The United Nations Population Fund (UNFPA) recently has committed to providing more commodities, but the amount and timeline currently is unclear. In 2011, members of Parliament (MPs) complained about the lack of government investment in family planning, but specific sources for investment were not immediately forthcoming. At the time of finalizing this report, the Government of Tanzania had allocated 1 billion Tanzanian Shillings (approximately US\$611,000) in the line item for the upcoming budget year (2013/14).

¹³ Personal communication with EngenderHealth staff in Tanzania in May 2013.

Intermediate Result 2: Increased multisectoral coordination in the design, implementation, and financing of FP policies and programs

This IR assesses the extent to which various disciplines, such as health, education, agriculture, and the environment, as well as the public and private sectors, are involved in FP policymaking and implementation. Multisectoral structures can be any entities, bodies, partners made up of groups, or individuals from different sectors (government, nongovernment, civil society) and/or different disciplines (health, education, environment, etc.). In general, the team found numerous examples of multisectoral coordination, which will be reported under the various sub-IRs.

This IR area can also reflect demand for or social acceptability of family planning. For instance, this IR area includes indicators that reflect multisectoral involvement in strengthening the enabling environment for family planning (IR2). Multisectoral involvement, including entities representing community and religious groups, can reflect acceptance of and interest in family planning in the community.

IR2.1: Evidence of FP programs incorporated into national strategic and development plans

Family planning is incorporated into the *Poverty Reduction Strategy Paper 2010–2015*, the *National Population Policy 2006*, and the *Primary Health Services Development Programme 2007–2017*, among others (see Box 1).

Family planning is taken into account in various national programs, but often it is subsumed under the key mandate of each program. For example, in the MOHSW structure, family planning is incorporated into the work of the RCHS. As a result of this structure, family planning is given lower priority than the focal issue of each service, even if it clearly is important to those national programs.

Box 1: Key National Policies and Plans that Include Family Planning

- National Population Policy 2006
- National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths 2008–2015
- Poverty Reduction Strategy Paper 2010–2015
- Primary Health Services Development Programme 2007–2017

Poverty Reduction Strategy Papers (PRSPs) are used to shape development planning and help decide the priorities for the country and how its resources should be spent. Tanzania's first PRSP was active from 2005–2010, and a PRSP for 2010–2015 was also adopted.¹⁴ Multiple ministries, development partners, and coordinating agencies were consulted during the development of the PRSP for 2010–2015. Although the first PRSP reflected population issues to a certain extent, it provided no performance measures related to population, fertility, reproductive health, or family planning. The current PRSP was launched in December 2010 and includes targets for reducing the fertility rate and population growth in Tanzania. The PRSP specifies that access to modern contraceptives for women of reproductive age must be increased. The PRSP can be an effective addition to an FP advocacy toolkit when addressing ministries across the government sector, as well as subnational entities. Additionally, three ministries or agencies have included family planning in their policies or strategies. These include the National Population Commission, the Ministry of Gender and Women's Affairs, and the Ministry of Health and Social Welfare. Workshop participants noted that the Ministry of Education and Vocational Training (MOEVT) could strengthen support of family planning in its policies, curricula, and guidelines, but also indicated that family planning has been a controversial topic within this ministry.

IR2.2: Evidence of governments engaging multiple sectors in FP activities

The government has engaged or attempted to engage the private, NGO, and faith-based sectors in family planning. At the subnational level, there is a coordinator for the private sector. Workshop

¹⁴ Tanzania: Poverty Reduction Strategy Paper (2011 IMF).

participants noted that the private sector (pharmaceutical companies) trains both public and private sector medical personnel on the use of and information about specific contraceptive methods, and the government engages all of these sectors through a Contraceptive Security Working Group. The government also has engaged or attempted to engage the following disciplines/sectors in family planning: the Prime Minister's Office, health, finance, education, rural and infrastructural development, labor, gender, communication and technology, and social protection. Engagement by these ministries has been inconsistent, and in some cases the MOHSW has faced opposition from other ministries in the area of family planning. The FP TWG is a multisectoral structure that meets to promote repositioning family planning (see reference to the working group under SO.1). While the MOHSW has attempted to engage several ministries in the TWG, attendance and participation have been inconsistent.

IR2.3: Evidence of multisectoral structures that are established or strengthened to promote FP policy

The FP TWG is a multisectoral structure that meets to coordinate and promote family planning. Membership of the working group includes government, donor representatives, the private sector, and both local and international NGOs. The FP TWG has government support and authorization to work in a technical coordination role. The TWG has the authority to respond to issues or concerns; it guides the government and provides advice on FP topics, after which the government indicates approval and takes action. The chair is the National Family Planning Technical Coordinator, who reports to the Assistant Director of Preventive Services (also the Director of the Reproductive and Child Health Section), who reports to the Director of Preventive Services, who reports to the Chief Medical Officer, who reports to the Minister of Health. Some participants at the workshop expressed concern about the distance between the National Family Planning Technical Coordinator and key decisionmakers within the ministry.

IR2.4: Evidence of government support for private sector participation in family planning

This indicator assesses barriers to private sector participation, as well as the level of support or incentives the government provides to the private sector to strengthen the provision of family planning.

The Government of Tanzania is paying some attention to the private sector's participation in the provision of family planning. There are now private sector coordinators on family planning at subnational levels as well as a public-private partnership (PPP) coordinator at the national level. Furthermore, the government has given approval to private sector facilities to charge a minimum service fee for FP service consultation. Contraceptive commodities available at nongovernmental facilities, and procured through the public sector system (i.e., provided by the government of Tanzania), are supplied for free, but these facilities can charge a nominal service/consultation fee. The government has prepared service agreements with nongovernment facilities to provide family planning and other services; this freedom to charge a fee is vital to the survival of the FP program in private clinics. Unfortunately, workshop participants noted that some private sector providers feel that if the public sector is giving contraceptives away for free, they do not need to provide the service at all. Although there is some progress, the private sector is not engaged to the extent possible, and a stronger enabling environment for private sector participation could broaden access to family planning throughout the country.

Intermediate Result 3: Policies that improve equitable and affordable access to high-quality FP services and information adopted and put into place

One of the first components of repositioning family planning mentioned by respondents during the development of the framework was a strong FP policy and inclusion of family planning in national and subnational documents and plans. Based on country examples conveyed by USAID missions and implementing partners, as well as through the document review, it is clear that the mere existence of a policy, document, or plan is insufficient to ensure commitment to and resources for family planning.

This IR also includes indicators to measure the essential steps from policy to practice, including the existence of an operational plan, measures to address barriers to policy implementation, and evidence of actual policy implementation.

Adoption and implementation of policies often occur at different points in time. In some contexts, a policy first will need to be adopted; this would be reported using one indicator. If a policy is already in place and a plan is developed, a result corresponding to another indicator can be claimed. “Put into place” refers to various implementation mechanisms, such as adopting operational policies, establishing monitoring bodies, or training on how to use/implement policy or guidelines.

IR3.1: Existence of national or subnational policies or strategic plans that promote access to FP services and information

There is an adequate high-level policy framework for family planning in Tanzania, including a *National Population Policy*; the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008-2015*; *Essential Package of Services; FP/SRH Guidelines*; and *Primary Health Services Development Programme 2007–2017*.

Tanzania has several policies that promote access to FP services and information. The Government of Tanzania adopted the *National Population Policy* in 1992, which was revised in 2006. Since 1992, new developments have been taking place, both nationally and internationally, that have a direct bearing on population and development. These new developments required the government to revise the *National Population Policy*. Domestically, the economy has changed significantly, from being a centrally planned to a market-oriented economy with increasing participation by the private sector, which now plays a more active role in population and development issues. In June 1999, the government unveiled a new development vision, the *Tanzania Development Vision 2025*. The revised *National Population Policy 2006* has the goal of coordinating and influencing other policies, strategies, and programs that ensure sustainable development of Tanzania and promoting gender equality and the empowerment of women.

The *Primary Health Services Development Programme – MMAM 2007–2017* emphasizes the need for family planning to reduce maternal and under-five mortality by promoting the need for training 8,000 service providers from hospitals and health centers and family planning dispensaries.

The *Health Sector Strategic Plan III July 2009–June 2015* (HSSP) includes strategies to implement a plan for Maternal, Newborn and Child Health (MNCH), which addresses family planning interventions. The HSSP calls for “provision of youth-friendly reproductive health services to be promoted and availability of family planning methods and child health interventions to be increased.”

IR3.2: Existence of national or subnational policies or strategic plans that promote access to FP services and information for under-served populations

Tanzania’s policy documents aim to create an enabling environment for achieving the Millennium Development Goals, combating poverty, and promoting sustainable and sustained economic growth for the people of Tanzania. There is a need to focus on the country’s most under-served populations to ensure success in eliminating poverty and promoting growth. Several key policies that address family planning also briefly address the need to focus on under-served populations. For instance, the *National Population Policy 2006* refers to the needs of “special groups in society.” The NFPCIP promotes integrated services for youth, men, and women to meet the needs of vulnerable populations. “Economically disadvantaged” populations also are highlighted in the document. The *Primary Health Care Services Development Program (2007)* includes mention of the special needs of postpartum women and youth.

It is important to note that, while there are statements about under-served populations in these policy documents, the statements are general and could be segmented further or presented in more detail. A workshop participant noted that the TWG is now working on a policy focused on meeting the needs of under-served groups through outreach by integrating family planning into outreach visits for various health issues.

IR3.3: Documentation of instances in which a formal implementation or operational directive or plan is issued to accompany a national or subnational FP policy

The FP TWG developed an NFPCIP for 2010–2015.¹⁵ The main objective of the NFPCIP is to reposition and reinvigorate access to and use of FP services in Tanzania. The NFPCIP was developed as an informational tool to advocate for additional resources for family planning from the Tanzanian government and international donors. Several donor representatives and international NGOs provided technical assistance in the development of the NFPCIP, including costing, data analysis, modeling/forecasting, monitoring and evaluation, and strategic planning. The NFPCIP is being monitored by the RCHS (within the MOHSW) and the FP TWG, with significant support from international NGOs.

The NFPCIP concentrates on several strategic areas, including service provision and advocacy. Apart from highlighting the need for more resources for contraceptives, the plan specifically calls for increased attention to training and capacity building, noting that “many current providers have not had their FP knowledge and skills updated in several years, undermining the quality of care they provide.”

IR3.4: Evidence that policy barriers to access to FP services and information have been identified and/or removed

Over the past several decades, policy barriers to access to FP services and information have been identified and/or removed, but workshop participants did not provide specific information about the nature of the barriers and how they were addressed. Several policy barriers still remain. For example, the MOHSW is interested in having community health workers (CHWs) provide injectable contraceptive methods, but currently there are no guidelines for implementing this approach. There are no restrictions in the CHW job descriptions, but providing injectables currently does not appear in their job descriptions’ scope of practice. Additionally, workshop participants noted that, in many countries, CHWs have attended secondary school, are salaried, and have been trained in their profession for approximately nine months. In Tanzania, CHWs have an elementary education, are not salaried, and have not been trained as extensively as in other sub-Saharan African countries. This gap in education and knowledge is a concern.

Another policy barrier to accessing FP services is related to youth. Family life education (including contraception) is part of the official school curriculum, but coverage of the topic is uneven. Although FP advocates in the MOHSW and NGO sectors advocate for contraceptive services to be available at schools, the MOEVT currently does not allow this. In fact, the media in Tanzania recently reported instances of school officials expelling young people because they had caught the youth using contraceptives (condoms and implants). This lack of an MOEVT policy on comprehensive sex education and services for young people hinders access to knowledge and commodities for a population in need.

IR3.5: Evidence of the implementation of policies that promote FP services and information

FP TWG is charged with monitoring the implementation of national policies and plans related to the provision of FP services and information according to the monitoring plan in the NFPCIP. Some of the actions implemented on the basis of these policies and plans include the following:

- Promotional FP activities at all levels of the health system
- Free contraceptive commodities provided by the government
- Training and capacity building for service providers and community-based providers
- Advocacy among policymakers and community leaders regarding family planning
- Research on the needs, demand for, and acceptance of family planning at the community level

¹⁵ Ministry of Health and Social Welfare, The United Republic of Tanzania. *National Family Planning Costed Implementation Plan, 2010–2015*.

Additionally, there is evidence of family planning being incorporated at the subnational levels—specifically, in health plans at the district level. Some districts include family planning and allocate money to support it (see also IR1.3 above).

Intermediate Result 4: Evidence-based data or information used to inform policy dialogue, policy development, planning, resource allocation, budgeting, advocacy, program design, guidelines, regulations, and program improvement and management

This IR assesses the extent to which policies and programs are grounded in data and information to ensure a sound rationale for selecting the program strategies, activities, and other elements. Achievement of this indicator occurs when a policymaker (such as a minister of health) or representative from an NGO, on his or her own initiative, uses evidence-based information for policy dialogue, planning, or advocacy. Evidence of achievement for this indicator does not include dissemination (printing and distributing reports), but rather the actual use of the information for advocacy, policy dialogue, planning, resource allocation, and program improvement.

IR4.1: Evidence of data or information used to support repositioning FP efforts

There are numerous examples of the government and NGOs using data or information to support repositioning family planning in Tanzania. The development of the NFPCIP was informed by the FamPlan forecasting model, as well as other sources of evidence, to identify FP resource needs in Tanzania. The *Primary Health Services Development Programme – MMAM 2007–2017* was developed based on the *Tanzania Service Provision Assessment Survey 2006* to assess the availability of “basic services” in health facilities, including family planning. The FP TWG is particularly data driven; for instance, it constantly monitors and discusses contraceptive forecasts to determine whether additional resources are required to ensure a basic level of contraceptive security and uses regional statistics on service delivery, CPR, unmet need, etc., to discuss how best to concentrate and coordinate interventions.

IR4.2: Evidence of international FP best practices incorporated into national health standards

Several donor-funded international organizations currently are working with the MOHSW to revise and publish FP clinical guidelines, as well as clinical training manuals related to family planning, based on WHO Medical Eligibility Criteria (MECs) and Selected Practice Recommendations (SPRs) for contraceptive use. The MOHSW last updated the FP guidelines in 2005, but these updates were not disseminated widely to the district and facility levels. The MOHSW also updated training materials on family planning in 2011 to incorporate WHO guidelines.

IR4.3: Evidence of a defined and funded research agenda in family planning

The HPI/Tanzania team was unable to find evidence of an existing FP research agenda or funding allocated to FP research. However, workshop participants described the ongoing process to develop an FP research agenda, and stakeholders are aiming to have a national research agenda as an outcome of an FP Conference in Tanzania, scheduled for September 2013.

IR4.4: Evidence of in-country organizational technical capacity for the collection, analysis, and communication of FP information

Similar to the finding from IR4.3, HPI/Tanzania concluded that there is insufficient technical capacity to collect, analyze, and disseminate FP information at various levels of the health system. Although donor-funded projects and organizations are working to build country capacity in research, monitoring and evaluation, and evidence-based decisionmaking, stakeholders generally reported the same insufficient technical capacity. Some pointed to the lack of capacity at the district level to use service statistics and other data for planning and designing locally appropriate interventions as a missed opportunity.

Intermediate Result 5: Individual or institutional capacity strengthened in the public sector, civil society, and private sector to assume leadership and/or support the FP agenda

This result area measures strengthened capacity to support the FP agenda and ensure FP sustainability. Forms of capacity may include leadership, management, monitoring and evaluation, advocacy, policy development, and program content. This result area also reflects the importance of the involvement of varied sectors because well-positioned, prepared champions throughout the public, private, and NGO sectors play a vital role. Without strong local capacity, governments and NGOs may not be able to continue promoting family planning once donor support has shifted to competing priorities or left the country.

IR5.1: Evidence of entities provided with donor assistance that demonstrate capacity to independently implement repositioning FP activities

Based on workshop discussions and interviews with representatives of partners, government, donors, and NGOs, the team concluded that there are relatively few local NGOs working on family planning, especially FP policy and finance. In a review of the invitation list of the FP TWG, members include the MOHSW, international donors, international implementers, and local NGOs. Interviews we conducted in 2011 indicate that a limited number of NGOs are involved in FP advocacy at the national level. Additionally, several stakeholders noted that the culture of advocacy is not yet strong among NGOs or the public in general.

IR5.2: Evidence of government departments or other entities established or strengthened to support the FP agenda

The Reproductive and Child Health Section of the MOHSW, the FP TWG, and a parliamentary FP Club all support the FP agenda. The parliamentary FP Club has not been active on an ongoing basis since it was established in 2011; rather, it consists of a core group of parliamentarians that can discuss and promote family planning if mobilized—for instance, during annual budget discussions.

IR5.3: Evidence of targeted public and private sector officials, faith-based organizations, or community leaders publicly demonstrating new or increased commitment to family planning

Some traditional and religious leaders in Tanzania have made statements on the record about support for family planning, but others say that their religion does not allow family planning. Key messages by religious leaders have not been disseminated adequately in Tanzania. For instance, HPI/Tanzania worked with the Supreme Council of Muslims in Nigeria, as well as with the Council of Bishops, to promote family planning.

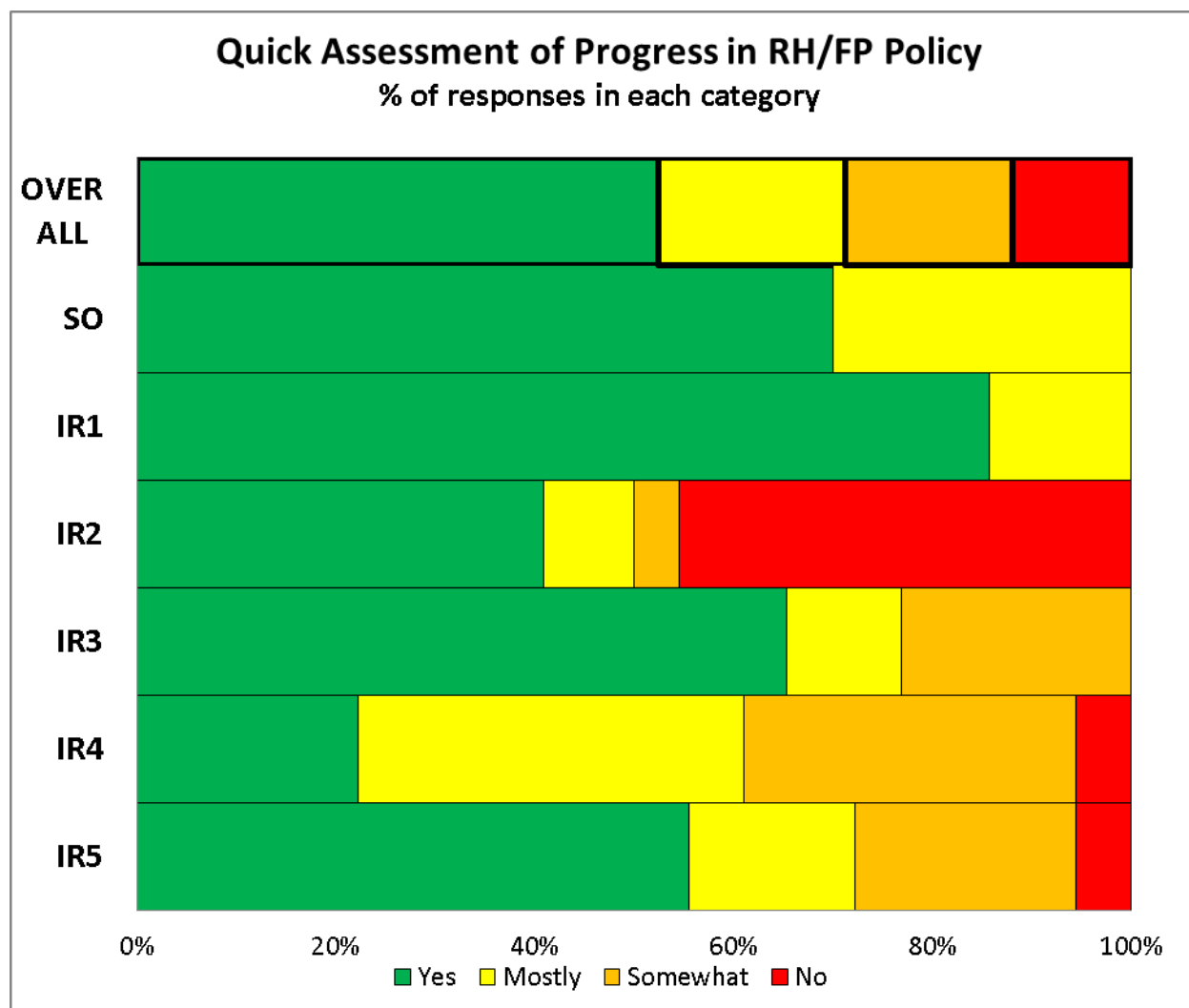
IR5.4: Number of regional/national centers or collaboratives for shared education and research in family planning

The team did not identify a reference center focused solely on family planning. However, participants in the working group said that several centers and departments at universities provide FP training and materials. For instance, the University of Dar awards a master's degree in demography; Muhimbili University awards a master's degree in communication; and universities have masters of public health programs that include elements of family planning.

RECOMMENDATIONS FOR REPOSITIONING FAMILY PLANNING IN TANZANIA

Tanzania has made considerable progress in creating a more enabling environment for family planning. Nevertheless, much still remains to be done to strengthen ongoing activities for repositioning family planning.

After discussing and responding to the questions linked to each indicator and scoring the country's performance in that particular area, the team presented the participants with a visual representation of progress made in repositioning family planning in Tanzania in a dashboard (see Figure 1 below). The participants then used this graphic to discuss strengths and opportunities for additional efforts to reposition family planning.



Participants at the working meeting made recommendations that relate to each of the IRs:

IR1: Resources for family planning increased, allocated, and spent more effectively and equitably

- Donors are providing the bulk of funding for contraceptive commodities, but this is not sustainable for the country. The government can take the next step to ensure that funding is put into the line item for family planning to purchase contraceptives. Ensuring a secure supply of reproductive health products, including contraceptives, is fundamental to the repositioning of family planning.

IR2: Increased multisectoral coordination in the design, implementation, and financing of FP policies and programs

- The government should increase multisectoral coordination in the design, implementation, and financing of policies and programs pertaining to family planning, including coordination between the MOHSW and the Ministry of Finance. More efforts could be made to engage ministries focused on economic development, rural development, youth, labor, and agriculture.
- The Ministry of Health and Social Welfare and the MOEVT need to strengthen their collaboration and engagement on the issues of family life education, contraception, and young people. In addition to a memorandum of understanding, the participants recommended that the ministries engage in dialogue to develop the following:
 - Joint guidelines on the provision of contraceptives to youth and allowing pregnant girls to continue their education; and
 - An approach to advocating revisions to Tanzania's Law of Marriage Act, which would raise the legal age of marriage for girls to at least 18.¹⁶

IR3: Policies that improve equitable and affordable access to high-quality FP services and information adopted and put into place

- The Government of Tanzania can do more to ensure that good policies are implemented. For instance, sometimes policies exist without adequate guidelines or standards for their implementation, or finances may not be allocated or released for implementation of the policies and plans.
- To implement a strong program for community-based distribution (CBD) of injectables, the MOHSW may need to revise existing or develop new policies and guidelines on task shifting/task sharing, community-based provision of oral contraceptives and injectables, and standards for training and employing CHWs. A program of this nature may require implementation of a more rigorous training program and requirements for CBD.

IR4: Evidence-based data or information used to inform advocacy, policy dialogue, policy development, planning, resource allocation, budgeting, program design, guidelines, regulations, and program improvement and management

- While data are used in policymaking and to develop guidelines for implementing the policy, public and private agencies working in family planning could better employ reliable data to inform planning, resource allocation, budgets, advocacy, and improvement of FP programs and management.
- The government and development partners should develop, fund, and implement an FP research agenda to ensure data are collected that respond to the needs of policymakers, planners, and service providers.
- Public and private sector organizations working in family planning could benefit from capacity-building initiatives focused on research, analysis, data communication, and data use.

IR5: Individual or institutional capacity strengthened in the public sector, civil society, and private sector to assume leadership and/or support the FP agenda

- Public and private agencies working in family planning should strengthen individual and institutional capacity within the public sector, civil society, and private sector to build the next generation of leaders/champions and broaden support for FP programs.

¹⁶ Under the 1971 Law of Marriage, the current legal age of marriage is 18 (boys) and 15 (girls), but courts can provide special permission to either sex to marry at age 14 if there are "special circumstances."

ANNEX I: KEY INFORMANTS (WORKSHOP PARTICIPANTS AND PERSONS INTERVIEWED)

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